U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 14 November 2003

CASE NO.: 2003-BLA -5197

In the Matter of:

JULIAN J. QUEVY
Claimant

v.

BARNES & TUCKER COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

APPEARANCES:

Robert J. Bilonick, Esq.
For the Claimant

John J. Bagnato, Esq.
For the Employer

Before: DANIEL L. LELAND
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

A formal hearing was held in Ebensburg, Pennsylvania on July 29, 2003, at which all parties were afforded full opportunity to present evidence and argument, as provided in the Act and the regulations found in Title 20 Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title. At the hearing, Director's exhibits (DX) 1-36, Claimant's exhibits (CX) 1-11, and Employer's exhibits (EX) 1, 3, 6, 8-11 were admitted into evidence. Employer submitted a closing brief.

ISSUES

I. Existence of total disability.

II. Causation of total disability.

III. Material change in conditions.

FINDINGS OF FACT AND CONCLUSIONS OF LAW[1]

Procedural History

Julian J. Quevy (Claimant or the miner) filed his first claim for benefits on December 16, 1976. Administrative Law Judge James W. Kerr, Jr. issued a Decision and Order – Denying Benefits on June 23, 1983. The Benefits Review Board affirmed Judge Kerr's denial of benefits on June 26, 1985. (DX 1). Claimant filed his second claim for benefits on January 30, 1990. (DX 2). The district director denied his claim on June 13, 1990. (DX 2). Claimant filed the instant claim for benefits on February 20, 2001. (DX 4). The district director denied his claim on August 19, 2002, finding that Claimant had not established that he was totally disabled due to pneumoconiosis. (DX 27). Claimant requested a formal hearing, and the case was forwarded to the Office of Administrative Law Judges on November 29, 2002. (DX 28, 33).

Background

Claimant was born on December 11, 1923, and has one dependent, his wife, Clare. (TR 16; DX 4). Employer stipulated that Claimant had twenty-six years of coal mine employment. (TR 11). Claimant testified that he worked in the mines for thirty-four years. (TR 17). His last job was in the cleaning plant. (TR 18). Claimant had to walk to different parts of the cleaning plant to check for problems and he had to ascend and descend seven flights of stairs. (TR 18). Claimant testified that his last position was outside of the mines, but that it was still dusty because he would clean up coal spillages and he had to clean the screens. (TR 18, 21). Claimant left coal mine employment in 1979 because it was too dusty. (TR 17).

Claimant first noticed problems with his breathing when he was still working in the coal mines. (TR 19). He testified that he would have to stop and take a breath while he was working, and that his breathing has gotten "worse and worse" over the years. (TR 19-20). Currently, Claimant cannot do any activities around the house because he "does not have enough wind."

[1] The following abbreviation has been used in this decision and order: TR = transcript of hearing.

(TR 24). Claimant had a lobectomy in September of 2000 in which a golf ball sized tumor was removed from his lower left lung. (TR 22-23). Claimant currently takes two breathing medications per day, which he has been taking since his lobectomy. (TR 22, 26). Claimant testified that he began smoking a couple of cigarettes at the age of twelve, but he seldom smoked a pack per day. Claimant quit smoking cigarettes six months ago. (TR 20).

Medical Evidence[2]

Pulmonary Function Studies

Exhibit	Date	Height	Age	FEV1	FVC	MVV
DX 1	2/1/77	66"	53	1.0	1.2	28.4
DX 1	9/4/79	66"	55	2.90	4.22	77
DX 2	6/13/80	68.5"	56	1.71	2.79	69
DX 1	8/19/80	66"	56	2.61	3.40	81
DX 1	7/27/81	66"	57	1.80	2.11	49.8
				2.75*	3.29*	89.2*
DX 2	2/22/90	66"	66	1.71	1.73	63.48
DX 2	4/2/90	65"	66	3.14	4.64	106
				2.60*	3.72*	114.54*
DX 12	1/15/01	64"	77	1.60	2.44	29
				1.73*	2.46*	29*
DX 17	3/27/01	65"	77	1.46	1.90	49
				1.56*	2.77*	49*
DX 20	4/19/01	66"	77	1.59	2.74	47
				1.76*	2.28*	62*
EX 6	3/14/02	63.5"	78	1.39	2.67	55
				1.54*	2.98*	---

* results post-bronchodilator

Dr. Robert G. Pickerill, a board-certified pulmonologist, reviewed the results of the January 15, 2001 pulmonary function study. (DX 13).[3] He stated that the MVV was technically invalid because of sub-optimal respiratory rates of less than sixty breaths per minute. He also

[2] As pneumoconiosis and the causal relationship between pneumoconiosis and coal mine employment are not contested issues, the chest x-ray evidence will not be summarized. (TR 11).

[3] Employer also submitted a letter from Dr. Fino reviewing the January 15, 2001 pulmonary function study. (EX 1). Section 725.414(a)(3)(ii) states that the responsible operator is entitled to submit, as rebuttal evidence, no more than one physician's interpretation of each pulmonary function test submitted by the claimant. As Employer already submitted Dr. Pickerill's letter as rebuttal evidence to Claimant's January 15, 2001 pulmonary function study, I find that Dr. Fino's letter is not proper rebuttal evidence. Therefore, Dr. Fino's letter dated March 15, 2001 is stricken from the record.

stated that the FVC tracings lacked smooth exhalation and there was premature termination of maximal expiration. Dr. Pickerill concluded that the spirometry was technically invalid.

Dr. John Michos validated the March 27, 2001 pulmonary function study on June 16, 2001. (DX 17).

Blood Gas Studies

Exhibit	Date	PCO2	PO2
DX 1	9/4/79	35	80
		33*	80*
DX 2	6/13/80	33	77
DX 2	2/22/90	39	74
		37*	70*
DX 2	5/1/90	38	73
		38*	81*
DX 17	3/27/01	42	81
DX 20	4/19/01	43	72
		42*	86*
EX 6	3/14/02	42	72

* exercise values

Medical Reports

Claimant was examined by Dr. Robert G. Shaheen on February 1, 1977. (DX 1). Claimant reported a persistent productive cough for three to four years and shortness of breath on exertion, on a slight hill, or ascending stairs. The physical examination was normal. Dr. Shaheen diagnosed obstructive and restrictive airways disease, and he determined that Claimant was not disabled due to coal mine work.

Claimant was examined by Dr. Joseph R. Sabo on August 29, 1979. (DX 1). Dr. Sabo noted that Claimant smoked one pack of cigarettes per day for forty years, and that he quit smoking in 1978. Claimant complaints were: cough for two years, wheezing on exertion for two years, and dyspnea on exertion for five to six years. The physical examination was normal. Dr. Sabo diagnosed moderate emphysema due to cigarette smoking, mild chronic bronchitis due to cigarette smoking, and mild to moderate pneumoconiosis.

Dr. Robert F. Klemens examined Claimant on August 19, 1980, and his findings are contained in a report dated August 26, 1980. (DX 1). Claimant complained of shortness of breath and a productive cough. Dr. Klemens reported that Claimant smoked less than one pack of cigarettes per day, and that he quit smoking one year ago. The physical examination was normal. A chest x-ray and pulmonary function study were performed. Dr. Klemens diagnosed coal workers' pneumoconiosis. He opined that Claimant is totally and permanently disabled because his coal workers' pneumoconiosis is causing his shortness of breath.

Dr. G.W. Strother, a board-certified pulmonologist, examined Claimant on July 27, 1981, and his findings are summarized in a report dated July 29, 1981. (DX 1). Dr. Strother noted that Claimant smoked an average of twelve cigarettes per day for thirty-four years, and that he quit smoking cigarettes seven years ago. He also noted that Claimant smoked a pipe for five years and that he currently smokes six small cigars per day. Claimant complained of a productive cough for four to five years and shortness of breath when walking two hundred feet, up a hill, or ascending stairs. The physical examination was normal. Dr. Strother diagnosed chronic bronchitis based on Claimant's history of a chronic productive cough. He opined that Claimant's chronic bronchitis was due to cigarette smoking with minimal influence from coal dust exposure. Dr. Strother stated that Claimant gave suboptimal cooperation and effort on the pulmonary function testing. However, one forced vital capacity maneuver in the post-bronchodilator phase and one maximal voluntary ventilatory maneuver were done with reasonable effort, and so Dr. Strother concluded that Claimant did not have a lung impairment and that he could perform his last job.

Claimant was examined by Dr. Glicerio V. Ignacio on February 21, 1990. (DX 2). Dr. Ignacio noted that Claimant occasionally smoked for many years, and that he quit smoking in 1987. Claimant complained of a productive cough since 1971, dyspnea since 1971, and some wheezing. Claimant reported that he becomes short of breath after running twenty-five feet, walking one block, or ascending two flights of stairs. Dr. Ignacio noted diminished breath sounds upon examination. A chest x-ray, pulmonary function study, arterial blood gas test, and electrocardiogram were performed. Dr. Ignacio diagnosed pneumoconiosis, mild hypoxemia, and a history of chronic obstructive pulmonary disease. Dr. Ignacio opined that Claimant's thirty years of coal mine employment caused his pneumoconiosis, and that there are no contributory factors because Claimant only smoked occasionally. He also opined that Claimant's hypoxemia is secondary to his pneumoconiosis. He could not determine whether Claimant has chronic obstructive pulmonary disease because the spirometry was invalid. Dr. Ignacio concluded that Claimant has a mild impairment.

Dr. Strother examined Claimant and his findings are found in a report dated April 9, 1990. (DX 2). Dr. Strother noted that Claimant smoked an average of twelve cigarettes per day for thirty-four years, and that he quit smoking seventeen years ago. He also noted that Claimant quit smoking cigars six years ago and that he smoked a pipe for five years. Claimant complained of a productive cough for twelve years and shortness of breath when walking two blocks or ascending a flight of stairs. Claimant reported that he can perform household chores and that he gardens. The physical examination was normal. Dr. Strother diagnosed chronic bronchitis based on Claimant's daily chronic productive cough. He concluded that Claimant does not have pneumoconiosis because the chest x-ray was negative. The pulmonary function study was normal and the chronic bronchitis has not caused any lung impairment, so Dr. Strother concluded that Claimant is able to perform his last coal mine work.

Dr. John T. Schaaf, a board-certified pulmonologist, examined Claimant and reviewed his medical records, and his findings are in a report dated January 18, 2001. (DX 12). Dr. Schaaf noted that Claimant has experienced shortness of breath since 1967 and currently he can walk two to three blocks or ascend one flight of stairs before becoming short of breath. Claimant also complained of a chronic productive cough and wheezing. Dr. Schaaf reported that Claimant

smoked three-quarters of a pack of cigarettes per day from 1935 to 1996. The physical examination was normal. Dr. Schaaf diagnosed coal workers' pneumoconiosis based on the abnormal chest x-rays, Claimant's history of coal mine employment, and the pathologic evidence. He also diagnosed dyspnea due to coal workers' pneumoconiosis based on the presence of pneumoconiosis and the absence of an alternative explanation, such as heart disease, obstructive airways disease, or another condition causing breathlessness. Dr. Schaaf also performed a pulmonary function study, which revealed a mild obstructive and some restrictive lung disease.

Dr. William J. Paronish, Claimant's treating physician and board-certified in family and geriatric medicines, authored a letter dated March 9, 2001. (DX 15; CX 6). Dr. Paronish stated that Claimant has coal workers' pneumoconiosis based on the pathologic evidence. Dr. Paronish stated that he last saw Claimant on September 12, 2000, at which time he had dyspnea on exertion. Dr. Paronish stated that Claimant was impaired by lung disease at the time of his last visit, which he attributed to coal mine employment and tobacco smoking. Based on the last examination, he determined that Claimant cannot perform his last coal mine job.

Dr. Stephen T. Bush, who is board-certified in anatomic and clinical pathology, reviewed the pathologic evidence and prepared a consultative report dated April 18, 2001. (DX 16). Dr. Bush noted rare coal worker micronodules measuring up to 0.1 cm in the parenchyma and tiny silicotic pleural nodules measuring 0.1 cm or less. He stated that only a fraction of one percent of the lung tissue is involved by coal workers' pneumoconiosis. He also noted minimal focal dust emphysema surrounding the coal worker micronodules in the parenchyma and minimal centrilobular emphysema in the pulmonary parenchyma. Dr. Bush determined that Claimant has a mild degree of simple coal workers' pneumoconiosis. He stated that coal workers' pneumoconiosis has no causal relationship to the development of adenocarcinoma, and in fact studies have shown that carcinoma of the lung is not more common in coal miners than in the general population. Dr. Bush concluded that the degree and extent of Claimant's pneumoconiosis is so limited that one would not expect pulmonary impairment to result from his lung lesions.

Claimant was examined by Dr. George M. Zlupko, who is board-certified in internal medicine, on March 27, 2001. (DX 17; CX 7). Dr. Zlupko noted that Claimant smoked between one-half to three-quarters of a pack of cigarettes per day from 1938 to 1999. Claimant complained of a daily productive cough, wheezing with exertion, shortness of breath with exertion, and orthopnea. The physical examination was normal. Dr. Zlupko performed a chest x-ray, pulmonary function study, arterial blood gas test, and an electrocardiogram. He diagnosed moderate to severe obstructive ventilatory impairment based on the pulmonary function study, adenocarcinoma of the lung and moderate to severe simple coal workers' pneumoconiosis based on the pathologic evidence, and cardiac irregularities based on the electrocardiogram. Dr. Zlupko opined that Claimant's conditions are due to cigarette smoking and coal workers' pneumoconiosis. He stated that Claimant's carcinoma of the lung is "probably related mostly to long history of cigarette smoking." (DX 17, p. 4). Dr. Zlupko concluded that Claimant is totally and permanently disabled as a result of his severe chronic obstructive pulmonary disease. He stated that Claimant's pulmonary disease, cigarette smoking history, chronic obstructive pulmonary disease associated with coal workers' pneumoconiosis, and lung cancer all

contributed to his current functional impairment, and that the extent of each condition's contribution cannot be determined.

Dr. John J. Solic, a board-certified pulmonologist, examined Claimant and reviewed his medical records, and his findings are in a report dated July 3, 2001. (DX 20). Dr. Solic noted that Claimant has a forty-plus pack year history of smoking little cigars and pipes, and that he still occasionally smokes. He also noted that Claimant quit smoking off and on throughout the years. Claimant's complaints were: morning productive cough, wheezing rarely, dyspnea on stairs, and shortness of breath since his lobectomy. Dr. Solic noted that Claimant did not have any major problems with breathing before the summer of 2000. The physical examination revealed slightly decreased breath sounds at the left base posteriorly. Dr. Solic stated that the pulmonary function study was invalid due to Claimant's inability to adequately perform the maneuver. Dr. Solic found a minimal resting reduction in the p02 which improved after exercise. He found no evidence of a restrictive lung disease and stated that the diffusing capacity was normal considering the lobectomy, both of which are considered hallmarks of extensive pneumoconiosis leading to significant pulmonary symptomatology. Dr. Solic determined that Claimant's dyspnea on exertion is related to his post-operative state, mild obstructive airways disease due to smoking, and cardiovascular deconditioning. He concluded that Claimant is not disabled due to coal workers' pneumoconiosis.

Dr. Joshua Perper, who is board-certified in anatomic and forensic pathology, reviewed the pathologic and medical evidence and his findings are in a report dated June 12, 2001. (CX 4; CX 5). Dr. Perper noted the presence of variable, focal fibrosis and anthracosis, with presence of birefringent silica crystals in the pleura. He noted focal, centrilobular emphysema of variable severity, from mild to moderate, in the pulmonary parenchyma. Dr. Perper also noted pneumoconiotic nodules with anthracotic pigmentation, slight fibrosis, and the presence of birefringent silica crystals scattered throughout the pulmonary parenchyma. He stated that many of the macules are smaller than 1 mm, but some measure up to 1-2 mm and in some places the macules are in small aggregates, showing peripheral scar emphysema. Dr. Perper also noted a few rare micronodules of both silicotic and mixed coal dust type, primarily 1-2 mm in size, adjacent to the scar emphysema, and together involved twenty percent of the total lung section. Further, he noted that there were severe anthraco-silicotic changes in the lymph nodes. After reviewing the pathologic slides, Dr. Perper diagnosed: adenocarcinoma of the lung, moderately well-differentiated; simple coal workers' pneumoconiosis, mild, primarily macular, with focal emphysema, and few micronodules; severe anthracosilicosis of pulmonary lymph nodes; centrilobular emphysema, variable, focal, mild to severe; and chronic bronchitis and bronchiolitis, mild. Dr. Perper diagnosed coal workers' pneumoconiosis based on Claimant's history of coal dust exposure, clinical findings, and radiographic and pathologic findings. He also diagnosed centrilobular emphysema and chronic obstructive pulmonary disease based on the radiographic and clinical findings. Dr. Perper attributed Claimant's pulmonary cancer and centrilobular emphysema to his exposure to coal dust with silica. Dr. Perper opined that coal workers' pneumoconiosis is a substantial cause of Claimant's disability, primarily through "the causally associated squamous cell cancer of the right [sic] lung and the associated centrilobular emphysema." (CX 4, p. 15). Further, Dr. Perper related Claimant's adenocarcinoma of the lung to his coal dust exposure based on the numerous collections of silica crystals in the lung sections, the silicotic nodules in the lung, and the mixed coal dust pneumoconiotic nodules. Dr. Perper

opined that Claimant's coal workers' pneumoconiosis and adenocarcinoma of the lung render him totally and permanently disabled.

Dr. Gregory J. Fino, a board-certified pulmonologist, examined Claimant and reviewed the medical evidence, and his findings are contained in a report dated April 26, 2002. (EX 6; EX 1). Claimant reported that he smoked one-half a pack of cigarettes per day for more than sixty years, but that he quit smoking many times over the years. He also reported that he smoked three pipe bowls a day for five to six years. Claimant's complaints were: daily productive cough, wheezing, and shortness of breath for twenty-two years, which interferes with his daily activities. Claimant reported that he becomes dyspneic when walking at own pace on level ground or ascending one flight of stairs, lifting and carrying, or performing manual labor. Dr. Fino noted diffuse rhonchi and wheezing in both lungs upon examination. The pulmonary function study revealed moderate obstruction with bronchodilator response and the arterial blood gas test was normal. Dr. Fino diagnosed simple coal workers' pneumoconiosis, very mild to mild obstructive ventilatory defect, and obstructive abnormality due to smoking. He opined that Claimant's obstructive ventilatory defect did not result in a clinically significant impairment. He also opined that the obstructive abnormality is not due to coal dust exposure because Claimant's pulmonary function tests were normal when he left the mines, and the abnormality only developed recently. Dr. Fino determined that after his surgery in 2000, Claimant's combined obstructive defect and ventilatory impairment due to the resection of his lung would prevent him from being able to perform his last coal mine job. Dr. Fino attributed Claimant's impairment to his cigarette smoking and a twenty-five percent reduction in lung functioning due to the lobectomy. Moreover, he stated that Claimant's cancer was unequivocally related to his cigarette smoking, and he cited medical studies which showed that there is no causal connection between coal dust exposure and lung cancer.

Dr. Schaaf was deposed on November 4, 2002. (CX 9). Dr. Schaaf testified that the pulmonary physical examination was normal. (CX 9, p. 33). He noted that Claimant smoked three-quarters of a pack of cigarettes per day for sixty-plus years, which he considered a "mild" smoking history. (CX 9, p. 35). Dr. Schaaf explained that Claimant has a mild impairment based on the mild obstruction revealed on the pulmonary function study. (CX 9, p. 15). He testified that Claimant's total lung capacity is not affected by the lobectomy. (CX 9, p. 17). Dr. Schaaf determined that Claimant's cancer is due to smoking and coal dust exposure, but could not exclude either factor. (CX 9, p. 25). He opined that Claimant's pulmonary impairment is due to coal workers' pneumoconiosis, and that he cannot perform his last coal mine job. (CX 9, pp. 26, 28). Dr. Schaaf acknowledged that Claimant's breathing complaints could be related to his smoking. (CX 9, p. 36).

Dr. Solic was deposed on November 25, 2002. (EX 9). Dr. Solic diagnosed coal workers' pneumoconiosis based on the radiographic and pathologic evidence and chronic bronchitis based on Claimant's complaint of a daily productive cough. (EX 9, pp. 10-11, 23). Dr. Solic attributed Claimant's obstructive lung disease and chronic bronchitis to his history of smoking and his lung cancer. (EX 9, p. 12). Dr. Solic testified that Claimant's coal dust exposure is not a significant factor in his impairment based on the pulmonary function results. (EX 9, p. 27). He testified that Claimant has a reduced FEV1 and a reversible obstruction and large airways obstruction based on the FEV1, which is more consistent with cigarette smoking

than coal dust exposure. (EX 9, pp. 13, 29). He also testified that Claimant's diffusing capacity and oxygen transfers are normal, which suggest that Claimant's obstructive lung disease is due to tobacco smoking. (EX 9, p. 14). Moreover, Dr. Solic testified that the medical literature demonstrates that there is no causal connection between coal dust exposure and the development of lung cancer. (EX 9, p. 13). Dr. Solic opined that Claimant is disabled due to his obstructive airways disease due to smoking and his lobectomy, with a majority of his disability due to the lobectomy (at the time of his examination). (EX 9, pp. 15, 28).

Dr. Fino was deposed on December 4, 2002. (EX 10). In addition to pneumoconiosis, Dr. Fino diagnosed a smoking-related obstruction based on Claimant's pulmonary function study evidence and smoking-related cancer of the lung based on the radiographic and pathologic evidence. (EX 10, p. 16). He testified that "smoking-related obstruction" refers to chronic bronchitis. (EX 10, p. 50). Dr. Fino examined Claimant's pulmonary function studies from 1980, and determined that Claimant did not develop an obstructive lung disease until 1990, ten years after he left coal mine employment but while he still smoked cigarettes. (EX 10, p. 21). Dr. Fino testified that the medical literature shows that a coal dust-induced obstruction "begins early on in a coal miner's lifetime and is a function of the total and cumulative coal dust that the miner has inhaled. And at or about the time that you leave the mines for an obstructive abnormality it should be present if it was due to coal mine dust." (EX 10, p. 22). Because there was no obstruction until 1990, he concluded that Claimant's condition is due to tobacco smoking. (EX 10, pp. 22-23). Dr. Fino testified that there are no causal connections between Claimant's lung cancer or his chronic obstructive pulmonary disease and coal dust exposure, and thus he opined that Claimant's conditions are due to smoking. (EX 10, p. 17). Dr. Fino concluded that from a pulmonary standpoint Claimant cannot perform his last coal mine job, but that his impairment is not related to coal dust exposure. (EX 10, pp. 24, 44).

Dr. Perper was deposed on March 3, 2003. (CX 10). Dr. Perper testified that the pathologic evidence revealed the presence of mild pneumoconiosis. (CX 10, p. 11). He testified that the presence of severe anthraco-silicotic changes in the lymph nodes is significant because it indicates that Claimant was exposed to coal dust containing silica. (CX 10, pp. 11-12, 20). Dr. Perper determined that twenty percent of Claimant's total lung section contains scar emphysema and micronodules, both of which are contributing to his pulmonary impairment. (CX 10, pp. 16, 20-21). Dr. Perper testified that there are sufficient changes in his coal workers' pneumoconiosis and its causally associated emphysema to account for Claimant's pulmonary symptomatology. (CX 10, p. 12). Dr. Perper explained that there is a causal link between Claimant's exposure to coal dust and his development of lung cancer because he was exposed to coal dust containing silica for twenty-eight to thirty-five years, and that Claimant's smoking history worked in tandem with his coal dust exposure in the development of his cancer. (CX 10, p. 15). He discussed medical literature which establishes that there is a causal link between coal dust exposure and the development of cancer. (CX 10, pp. 13-14, 16). Dr. Perper concluded that Claimant has a severe pulmonary impairment due to his coal workers' pneumoconiosis with associated chronic obstructive pulmonary disease and that he cannot perform his last coal mine job. (CX 10, pp. 17, 19). He opined that Claimant's coal dust exposure and smoking histories are significant and substantial factors to Claimant's pulmonary dysfunction. (CX 10, p. 18).

Dr. Paronish drafted a letter dated March 17, 2003. (CX 11). Dr. Paronish stated that he has been treating Claimant since 1985. He determined that Claimant has coal workers' pneumoconiosis based on the radiographic and pathologic evidence. Dr. Paronish explained that Claimant's respiratory impairment is multi-factorial because he has a history of smoking and coal dust exposure and he had part of his left lung removed. He opined that Claimant's coal dust exposure is playing a substantial role in his impairment because there is radiographic evidence of fibrotic lung disease, clinical evidence of industrial bronchitis, and no evidence of emphysema (which is indicative of a smoking-related disease). Dr. Paronish concluded that Claimant cannot perform his last coal mine job because Claimant becomes quite symptomatic with minimal exertional activity.

In a letter dated April 5, 2003, Dr. Bush discussed medical literature demonstrating that there is no causal link between coal dust exposure and the development of cancer, contrary to the opinion of Dr. Perper. (EX 8).

Dr. Bush was deposed on June 6, 2003. (EX 11). Dr. Bush diagnosed minimal coal workers' pneumoconiosis because less than one percent of the lung tissue was involved by coal worker lesions. (EX 11, pp. 15-16). Dr. Bush also diagnosed centrilobular emphysema and focal emphysema. (EX 11, pp. 16, 33). He disagreed with Dr. Rizkalla's diagnosis of macular and micronodular coal workers' pneumoconiosis, moderate to severe because of the limited extent of changes and the small size of the lesions. (EX 11, p. 17). Dr. Bush concluded that Claimant's pulmonary functioning would not be impaired by the minimal amount of coal workers' pneumoconiosis, centrilobular emphysema, or focal emphysema. (EX 11, pp. 17-18, 57-58). He criticized the medical literature cited by Dr. Perper at length, discussing how the studies do not demonstrate a causal connection between coal dust containing silica and the development of cancer, but rather the causal connection between silica exposure in other occupations and cancer. (EX 11, pp. 20-30). Moreover, Dr. Bush testified that the presence of tiny silicotic nodules in the lymph nodes and a few birefringent particles consistent with silica and silicates are not the equivalent of a diagnosis of silicosis, but rather only indicate that Claimant has been exposed to silica and has experienced minimal changes due to that exposure. (EX 11, pp. 54-55). Dr. Bush disagreed with Dr. Perper's diagnosis of silicotic nodules in the lungs and his relating of the nodules to Claimant's cancer. Dr. Bush observed small, tiny lesions beneath the pleura that did not affect any lung tissue and in the lymph nodes, but since Claimant's carcinoma was not in the lymph nodes, their presence is unrelated to the cause of Claimant's cancer. (EX 11, pp. 32-33). Dr. Bush testified that thereis no pathologic explanation for Claimant's pulmonary impairment; he acknowledged that he only looked at the left lower lobe and that the other lobes could be more diseased. (EX 11, pp. 58-59).

Hospital Records

The record includes Claimant's medical records from Miners Hospital. (CX 8). On September 15, 2000, Claimant had a left lower lobectomy. The pathologist made the following diagnoses: moderate to poorly differentiated adenocarcinoma of the lung, pulmonary macules and micronodules consistent with coal workers' pneumoconiosis, and anthracosis and hyalinization evidence in the lymph nodes. Dr. Waheeb Rizkalla was consulted on November 9, 2000, and diagnosed: moderately differentiated adenocarcinoma, moderate to severe simple coal

workers' pneumoconiosis (macular and micronodular), hylanized anthrasilicotic nodules in the lymph nodes, and focal dust emphysema.

Conclusions of Law

This claim was filed after January 19, 2001, and is governed by the amended regulations. As the present claim is the miner's third claim for benefits, and it was filed more than one year after the denial of the miner's prior claim, the evidence must "demonstrate that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final," or else the claim will be denied. § 725.309(d); *see also LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995). None of the elements of entitlement were found to be established in the miner's previous claim, which was denied by the district director on June 13, 1990. At the hearing, Employer stipulated to the existence of pneumoconiosis and the causal relationship between pneumoconiosis and coal mine employment, and thus a material change in conditions has been demonstrated. All of the evidence must now be evaluated to determine if Claimant is totally disabled due to pneumoconiosis.

A miner shall be considered totally disabled if the irrebuttable presumption in § 718.304 applies. If that presumption does not apply, a miner shall be considered totally disabled if his pulmonary or respiratory impairment, standing alone, prevents him from performing his usual coal mine work and comparable and gainful work. § 718.204(b)(1). In the absence of contrary probative evidence, a miner's total disability shall be established by pulmonary function studies showing the values equal to or less than those in Appendix B, blood gas studies showing the values in Appendix C, the existence of cor pulmonale with right sided congestive heart failure, or the reasoned and documented opinion of a physician finding that the miner's pulmonary or respiratory impairment prevents him from engaging in his usual coal mine work and comparable and gainful work. § 718.204(b)(2).

The record contains eleven pulmonary function studies. Three of the pulmonary function studies (all pre-bronchodilator) produced qualifying values. I find that the pulmonary function study evidence does not establish that Claimant is totally disabled.

The record contains seven arterial blood gas tests, none of which produced qualifying values. I find that the arterial blood gas test evidence does not establish that Claimant is totally disabled.

There is no evidence that Claimant has cor pulmonale.

There are eleven physician opinions that address whether Claimant is totally disabled.[4] Drs. Fino, Klemens, Paronish, Perper, Schaaf, Solic and Zlupko concluded that Claimant is disabled to the extent that he cannot perform his last coal mine work. Drs. Ignacio, Shaheen and Strother concluded that Claimant is not totally disabled. Dr. Bush stated that he would not

[4] Dr. Sabo did not discuss whether Claimant suffers from a pulmonary or respiratory impairment, and thus his opinion is not probative on this issue.

expect Claimant to suffer from a pulmonary impairment based on the degree and extent of affected lung tissue. I find Dr. Bush's opinion to be equivocal, and accord it little weight. *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236 (1984). Drs. Ignacio, Klemens, Shaheen, and Strother's opinions are between thirteen and twenty-six years old. I find that their reports are not representative of Claimant's current condition, and thus accord them little weight. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985); *Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984). I find that the medical opinions of Drs. Fino, Paronish, Perper, Schaaf, Solic and Zlupko are well-documented and well-reasoned because they explained the clinical findings and objective medical evidence upon which their opinions are based and the medical evidence supports their conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). I accord great weight to the opinions of these physicians. Therefore, I find that a preponderance of the physician opinion evidence establishes that Claimant is totally disabled.

A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's total disability if it has a material adverse effect on his respiratory or pulmonary impairment or it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. § 718.204(c)(1).

Drs. Paronish, Perper and Schaaf opined that Claimant's pneumoconiosis is a substantial cause of his total disability. Drs. Fino and Solic attribute Claimant's disability to his obstructive lung defect due to smoking and the effects of his lobectomy. Dr. Zlupko stated that Claimant's pulmonary disease, smoking history, chronic obstructive pulmonary disease due to coal workers' pneumoconiosis and lung cancer are contributing to his disability, but Dr. Zlupko could not determine the contributory extent of each condition.

Dr. Paronish found that Claimant's impairment is multi-factorial, but opined that his history of coal dust exposure is playing a substantial role in Claimant's impairment because of the radiographic evidence, the clinical evidence, and there is no evidence of emphysema. First, I find that Dr. Paronish is not entitled to greater weight than the other physicians based on his status as Claimant's treating physician because the factors in § 718.104(d) have not been satisfied. Second, Dr. Paronish minimized the role that Claimant's smoking history played in his impairment because there is no evidence of emphysema. However, Drs. Bush and Perper diagnosed focal and centrilobular emphysema and Dr. Rizkalla diagnosed focal dust emphysema from the pathologic slides. It is not clear if Dr. Paronish reviewed their medical reports, but the fact that the record does contain evidence of emphysema raises questions about his conclusions and whether he properly focused on coal dust exposure as the substantial cause of Claimant's impairment. Moreover, Dr. Paronish's March 17, 2003 letter offers a lengthy discussion of why Claimant's coal dust exposure is a substantial cause of his impairment, but his opinion is based on nothing more than Claimant's history of coal mine employment. I find that Dr. Paronish's opinion is not well-documented or well-reasoned, and thus I accord it little weight.

Dr. Perper concluded that Claimant's coal workers' pneumoconiosis, emphysema associated with pneumoconiosis, and the lobectomy are contributory causes of his impairment. Dr. Perper opined that Claimant's coal dust exposure and smoking histories are "significant and

substantial factors" of his pulmonary dysfunction and thatneither can be ex cluded. (CX 10, p. 18). Dr. Perper discussed medical literature that causally linked cigarette smoking and coal dust exposure (separately) to emphysema and lung cancer, but he did not discuss how he determined that smoking and coal dust exposure caused Claimant's conditions. Also, Dr. Perper did not explain why coal workers' pneumoconiosis is a contributory cause of Claimant's disability in light of his classification of the pneumoconiosis as "mild." (CX 10, p. 1). I find that Dr. Perper did not adequately discuss the bases of his opinion, and thus I accord his opinion little weight.

Dr. Schaaf concluded that Claimant is totally disabled due to coal workers' pneumoconiosis. Dr. Schaaf explained that he ruled out cancer as a cause of Claimant's disability because it was completely removed during the lobectomy in 2000. (CX 9, p. 26). He also ruled out the effects of the lobectomy as a cause of his disability because Claimant's total lung capacity was normal after the lobectomy. (CX 9, p. 27). While Dr. Schaaf acknowledged Claimant's smoking history (CX 9, p. 35), he did not explain why he concluded that Claimant's disability is due to coal dust exposure rather than cigarette smoking or a combination of both exposures. Therefore, I accord less weight to the opinion of Dr. Schaaf.

Dr. Zlupko concluded that Claimant is totally disabled and stated that his pulmonary disease, cigarette smoking, chronic obstructive pulmonary disease associated with coal workers' pneumoconiosis, and lung cancer all contributed to his disability. However, Dr. Zlupko could not determine the extent of each condition's contribution. I find that Dr. Zlupko's opinion is not sufficient to establish that pneumoconiosis is a substantially contributory cause of Claimant's disability.

Drs. Fino and Solic concluded that Claimant is totally disabled due to his obstructive airways disease due to smoking and the effects of his lobectomy. Dr. Solic explained that he attributed Claimant's obstructive lung disease to cigarette smoking because his FEV1 was reduced and his diffusing capacity and oxygen transfers were normal, which are more consistent with cigarette smoking than coal dust exposure. (EX 9, pp. 13-14, 29). Dr. Solic concluded that a majority of Claimant's disability is due to the lobectomy, as he examined Claimant less than one year after the surgery. Dr. Fino explained that he examined the pulmonary function studies dating back to 1980 and observed that Claimant's obstructive impairment developed in 1990, ten years after he left the mines but while he was still smoking. Dr. Fino stated that because Claimant did not have an obstructive defect when he left the mines and that he continued to smoke, his obstructive defect is due to cigarette smoking rather than coal dust exposure. (EX 10, pp. 21-23). I find that Drs. Fino and Solic's opinions are well-reasoned and supported by the objective medical evidence. Therefore, I find that their opinions are entitled to great weight.

After weighing all of the evidence, I find that Claimant has not established that he is totally disabled due to pneumoconiosis. His claim will therefore be denied. Claimant's counsel is precluded from receiving a fee for his legal work on this case.

ORDER

IT IS ORDERED THAT the claim of Julian J. Quevy is DENIED.

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DANIEL L. LELAND
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601***. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.